bedard
Pharmacy & Medical Supplies ☑
Phone: 207-784-3700 | Fax: 207-795-7622

Incontinence Supplies Detailed Written Order

1. Patient Information

Patient Name:_____ DOB:_____ Phone #:_____

Is patient currently in a facility? ☐ Y ☐ N If yes, Facility Name:_____ Facility Phone #:_____

2. Provider Information

Provider Name:_____ NPI #:_____ Phone #:_____

Fax #:_____

3. Diagnosis Information

ICD-10 Code: ☐ N39.3 Stress Incontinence (Female or Male) ☐ N39.41 Urge Incontinence ☐ N39.46 Mixed Incontinence

☐ R15 Fecal Incontinence ☐ R15.9 Full Incontinence of Feces ☐ R32 Unspecified Urinary Incontinence

☐ R39.81 Functional Urinary Incontinence ☐ Other:_____

4. Physician's Order / Prescription

Item	Absorbency Level	Frequency of Use	Day Supply	Refills
☐ Disposable Taped Briefs			☐ 19 ☐ 37 ☐ 73	
☐ Disposable Pullup Underwear			☐ 19 ☐ 37 ☐ 73	
☐ Bladder Control Pads			☐ 19 ☐ 37 ☐ 73	
☐ Disposable Underpads (CHUX)			☐ 19 ☐ 37 ☐ 73	
☐ Washable Reusable Underpads			*Up to 4 allowed per month* ☐ 1 ☐ 2 ☐ 3 ☐ 4	
☐ Exam Gloves *Insurance requires office notes documenting caregiver's need			☐ 19 ☐ 37 ☐ 73	
☐ Other				

Bedard will calculate quantity based upon patient frequency of use

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for incontinence supplies. I certify that I am the provider identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Provider Signature:_____ Date:_____